DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 04-008

2. STATE: Arizona

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1902(a)(13)(E)

7. FEDERAL BUDGET IMPACT:
a. FFY 2004-2005 $0
b. FFY 2005-2006 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B., pages 1 - 6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B., pages 1 - 6

10. SUBJECT OF AMENDMENT:
Interim outpatient fee schedule methodology effective through June 30, 2005.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [signature]

13. TYPED NAME:
Lynn Dunton

14. TITLE:
Assistant Director

15. DATE SUBMITTED:
June 29, 2004

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUNE 29, 2004

18. DATE APPROVED: JUL 22 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JULY 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL: [signature]

21. TYPED NAME: Linda Minamoto

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

State: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

The following is a description of methods and standards for determining payment rates for specific services when payments are made directly to providers. Fee-for-services payments are made in accordance with the Arizona Health Care Cost Containment System Fee-For-Service Provider Manual and are subject to the limitations set forth in Attachment 3.1-A of the State Plan.

- **Outpatient Hospital Services**

  Beginning with dates of service on and after March 1, 1993, AHCCCS shall reimburse hospitals for outpatient acute care hospital services by multiplying covered charges on an approved claim times the hospital-specific outpatient Medicaid cost-to-charge ratio. The cost reporting and claims data used for computation of the cost-to-charge ratio initially is the same as that described for inpatient hospital services in Attachment 4.19-A. Outpatient cost-to-charge ratios are computed for each hospital by determining the charges and costs associated with treating AHCCCS members in an outpatient hospital setting. Operating and capital costs are considered for the outpatient cost-to-charge ratio computations for each hospital. Medical education costs are excluded from the computation of outpatient cost-to-charge ratios because medical education costs are paid separately, as defined in Attachment 4.19-A.

  Beginning on July 1, 2004 through June 30, 2005, AHCCCS shall reimburse a hospital by applying a hospital-specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona Department of Health Services by more than 4.7 per cent for dates of service effective on or after July 7, 2004, the hospital-specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7 per cent, the effective date of the increased charges will be the effective date of the adjusted AHCCCS cost-to-charge ratio.

  Hospitals shall not be reimbursed for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, if the member is admitted as an inpatient to the same hospital directly from the emergency room, observation or other outpatient department. The emergency room, observation, and other outpatient hospital services provided before the admission are included in the tiered per diem payment.

  Outpatient hospital payments shall be subject to the quick pay discounts and the slow pay penalties described in Attachment 4.19-A.

  Annual Update

  AHCCCS shall rebase the outpatient hospital cost-to-charge ratio at least every one to four years using updated Medicare Cost Reports, and claim and encounter data.

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New Hospitals

New hospitals, as defined in Attachment 4.19-A, will be assigned the statewide average outpatient hospital cost-to-charge ratio.

Out-of-State Hospitals

Out-of-state hospitals will be paid the lesser of: a negotiated discount rate, the Arizona outpatient hospital statewide average cost-to-charge ratio, or if reasonably and promptly available, the Medicaid rate in effect on the date of service in the state in which the hospital is located.

Specialty Rates

The Administration may negotiate special contracted rates for outpatient hospital services provided in specialty facilities.

- **Laboratory Services and X-Ray**

AHCCCS' capped fee amounts will not exceed the reimbursement amounts authorized for clinical laboratory services under Medicare as set forth in 42 CFR 447.342.

- **Pharmacy Services**

Reimbursement is subject to the limitations set forth in 42 CFR 447.331 through 447.332.

- **EPSDT Services Not Otherwise Covered in the State Plan**

AHCCCS reimburses for chiropractor services using a capped fee schedule. Payment is the lesser of the provider's charge for the service or the capped fee amount established by AHCCCS.

AHCCCS reimburses for personal care services using a capped fee schedule. Payment is based on the lesser of the provider's charge for the service or the capped fee schedule established by AHCCCS.

AHCCCS reimburses for hospice services, including routine home care, continuous home care, inpatient respite care and general inpatient care. Payment is based on the annual hospice rate established by the Health Care Financing Administration.

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- **Organ Transplantation**

  As authorized in Attachment 3.1-E, AHCCCS reimburses for organ transplant services which are medically necessary and not experimental based on a competitive bid and/or negotiated flat rate process in accordance with State law. The rates are inclusive of hospital and professional services. If the service is provided in another state, AHCCCS will pay that state's approved Medicaid rate for the service or the negotiated rate, whichever is lower.

- **Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)**

AHCCCS will utilize the following payment methodology from January 1, 2001, forward.

1) AHCCCS will establish a baseline Prospective Payment System effective January 1, 2001. The calculation will conform to section 1902(a)(15)(c) of the Social Security Act. AHCCCS will use the center/clinic's fiscal year that ends during calendar year 1999 and 2000 for the base rate calculations. Each FQHC/RHC may elect to have rates adjusted by either the BIPA 2000 methodology, or the Alternative Payment Methodology. If the FQHC/RHC elects the BIPA methodology, the Medicare Economic Index (MEI) at the beginning of each federal fiscal year (October 1st) will be used to update rates on a prospective basis. If the FQHC/RHC elects the Alternative Payment Methodology, the Physician Service Index (PSI) subcomponent of the Medical Care component of the Consumer Price Index at the beginning of each federal fiscal year (October 1st) will be used to update rates on a prospective basis. Under either methodology, the baseline rates for 1999 and 2000 will be calculated based on the provider's cost data for the center/clinic's fiscal year that end during calendar year 1999 or 2000. Costs included in the base rate calculation will include all Medicaid covered services provided by the center/clinic. The calculated 1999 and 2000 base rates will be averaged by calculating a simple average of the costs per encounter for 1999 and 2000. The calculation is as follows:

   $$\frac{\text{Total Medicaid costs 1999 + Total Medicaid costs 2000}}{\text{Total visits 1999 + Total visits 2000}} = \text{Average Cost Per Visit}$$

   These base rates will then be indexed forward utilizing the MEI, from the midpoint of the cost report period being utilized, to the midpoint of the initial rate period (January 1, 2001 through September 30, 2001). Annually thereafter, the MEI for those FQHCs/RHCs selecting the BIPA methodology, or the PSI for those FQHCs/RHCs selecting the Alternative Payment Methodology, will be applied to the inflated-based rates at the beginning of the federal fiscal year (October 1st). AHCCCS and the FQHCs/RHCs have agreed to supplement payments to the FQHCs/RHCs payments once the PPS baseline is established, if necessary.

2) For a center/clinic that becomes a FQHC or RHC after FY 2000, AHCCCS will calculate the initial rate using data from an established FQHC or RHC in the same or adjacent area with a similar caseload. Absent an existing FQHC or RHC with a similar caseload, the center/clinic rate will be based on projected costs subject to tests of reasonableness. Costs would be subjected to reasonable cost definitions as outlined in Section 1833(a)(3) of the Act. If a center/clinic has inadequate cost data for one of the base periods, that

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center/clinic's rate will be established from the data that is available. If an existing center/clinic has inadequate data for both periods, they will be treated as a new center/clinic.

3) If the FQHC/RHC elects the BIPA methodology, and there is a change in scope of service, it will be the responsibility of the FQHC/RHC's to request AHCCCS to review services that have had a change to the scope of service. Adjustments will be made to the base rates on a case basis where the FQHC/RHC's can demonstrate that the increases or decreases in the scope of services is not reflected in the base rate and is not temporary in nature. If an FQHC/RHC requests a change in scope due to an increase in utilization for services included in the PPS, current utilization will be compared to the utilization used in the calculation of the PPS from appropriate rate adjustments. If it is determined that a significant change in the scope of service has occurred, the reasonable incremental cost per encounter from this change will be added to the PPS rate and a new rate will be established. A change will not be considered significant unless it impacts the base rate by 5% or more. This new rate will be effective on the date the change in scope of service was implemented.

4) If the FQHC/RHC elects the Alternative Payment Methodology, then every 3rd year, beginning with the federal fiscal year beginning October 1, 2004, AHCCCS will rebase the rate. The calculation will conform to section 1902(a)(15)(c) of the Social Security Act. AHCCCS will use the data from the center/clinic's fiscal years that end during the two previous calendar years for the rebase rate calculations. The baseline rates for the two previous years will be calculated utilizing the provider's cost data for the center/clinic's fiscal years that end during those two previous calendar years. Costs included in the rebase rate calculation will include Medicaid covered services provided by the FQHC/RHC pursuant to a contract with a MCE. The two calculated previous year base rates will be averaged by calculating a simple average of the costs per encounter for the two previous years. The calculation is as follows:

$$\frac{\text{Total Medicaid costs previous year 1} + \text{Total Medicaid costs previous year 2}}{\text{Total visits previous year 1} + \text{Total visits previous year 2}} = \text{Average Cost Per Visit}$$

These base rates will then be indexed forward utilizing the PSI from the midpoint of the cost report periods being utilized, to the midpoint of the initial rate period. For the next two years thereafter, the PSI will be applied to the inflated-based rates at the beginning of each federal fiscal year (October 1st).

5) FQHCs/RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive quarterly state supplemental payments for the cost of furnishing such services, that are an estimate of the difference between the payments the FQHC/RHC receives from MCEs and the payments the FQHC/RHC would have received under the BIPA PPS methodology. At the end of federal fiscal year, the total amount of supplemental and MCE payments received by each FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCEs would have yielded under the PPS. The FQHC/RHC will be paid the difference between the PPS amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC/RHC will refund the difference between the PPS amount calculated using the actual

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number of visits, and the total amount of supplemental and MCE payments received by the FQHC/RHC, if the PPS amount is less than the total amount of supplemental and MCE payments.

___ The payment methodology for FQHCs/RHCs will conform to section 702 of the BIPA 2000 legislation.

_X_ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for a Prospective Payment System.

___ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology.

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The following is a description of the methods and standards for determining the payment rate for case management services to the target group identified in Supplement 1 to Attachment 3.1-A.

DES/DDD is reimbursed, on a per member per month basis beginning October 1, 1997, to provide case management services to persons with developmental disabilities enrolled in the acute care program. AHCCCSA developed the per member per month capitation rate based on an analysis of average per member per month case management expenditures during the twelve month period from October 1, 1996 through September 30, 1997. Annually, this base rate is reviewed and updated, as necessary, by applying the inflation factor developed for the case management component of the ALTCS developmentally disabled capitation rate. Both the ALTCS developmentally disabled and the target group members are assigned to the same case managers. The inflation rate is determined by AHCCCSA's consulting actuaries based on data sources that include analysis of historic and future trends in case management expenditures, audited financial statements and case load requirements.

DES/DDD will be paid monthly on a capitated basis. This payment will be based on the capitation rate times the number of recipients verified as enrolled in the acute care program, as of the first of each month. The capitation payment will be made no later than ten working days after receipt of the DES/DDD data transmission.